Safeguarding Adults Review (SAR)

CASE 5/18

JOSH

Overview Report

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1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. Josh was a young man in his late twenties who was homeless and had diabetes. He had taken multiple overdoses of his insulin which resulted in a number of admissions to hospital due to self-neglect of his diabetes and misuse of medication. The taking of too much insulin (or not enough) leads to life threatening emergencies. As a result of a significant overdose of insulin, Josh suffered a permanent and life changing brain injury and it was believed that he was likely to have additional care and support needs for the rest of his life. Josh, however passed away unexpectedly in hospital just over three months later.

2. METHODOLOGY AND SCOPE

2.1. The Care Act 2014 states that a Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR). Full Terms of Reference, rationale for the scope and methodology of the review etc. for this SAR can be found in Appendix 1.

2.2. This review takes into account interagency involvement covering the six months prior to the date that Josh suffered the brain injury. This is the period that covers identification of a considerable number of contacts with agencies. Key background information will also form part of the review that will inform the more contemporary elements of Josh's journey.

3. FAMILY ENGAGEMENT

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to publication. It is documented that Josh was estranged from his family. TSAB made contact with a sister by letter via the coroner's office. A reply was received following after some time. The author made contact with the nominated family member who is a cousin of Josh's. The author and Board Manager met with Josh's two sisters, his cousin and Aunt and Uncle.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Josh had been known to services at a very young age. His formative years proved difficult with parental separation at 13 years old having an impact on him. He told mental health teams that he turned to substances to block out emotions. Historical information recorded in children's social care records suggests early substance misuse leading to anti-social behaviour and assaults within the family both from Josh and to Josh by his parents. This led to his mother requesting that he was taken into care. Josh described this event as being so that his mother could meet someone else. Family reflected that Josh and his mother had a very volatile relationship. A further assault on mother left Josh remanded to Local Authority care.

4.2. During a period of time being cared for by his Aunt and Uncle, Josh went back to school and did his GCSEs. Whilst this was quite a successful arrangement for a time, there was no legal agreement to this, and Josh chose to go back to live with his mother for a while.

4.3. Josh's ongoing substance misuse brought him to the attention of criminal justice systems through possession of substances as well as theft, possibly as a way of funding his substance misuse habit.

4.4. Josh's substance misuse continued to be a feature in his life with no evidence that he was motivated to change this for any length of time. The historical probation report for this review, suggested that Josh had stated that he had been drug free for a year and eight months before the scoping period of this review. Josh told mental health teams that he occasionally experienced suicidal thoughts in reaction to his circumstances and sought help with these.

4.5. Josh was diagnosed with type one diabetes mellitus (See Appendix two) when he was 18 years old. His lifestyle had always impacted on his ability to manage his diabetes, although it is clear that he understood his condition well.

4.6. Mental health records indicate a hospital admission for not taking his insulin in 2010, and again in 2015 for intentional overdoses of illicit substances. Family believe that the 2015 occurrences appeared to be due to the death of his grandfather who he was close to and having nowhere to spend Christmas. Further stressors occurred when he discovered that a child that he thought was his was found not to be on DNA testing when the child was just under a year old. Family say that he had formed a strong bond and love for the child. It was also during 2015 that Josh had a significant admission related to necrosis of his leg due to injecting into his foot, he spent some time in intensive care.

4.7. It is recorded that in December 2015, Josh was living in a structured support accommodation setting in Area B (See below). After six months, Josh was supported to relocate to Area A where his family were. This was two years before the scoping period.

4.8. Information from the family indicated that Josh had been supported by his Aunt, Uncle, his sisters and cousin for many years. They had offered all types of help and support but nothing that they offered made any difference to Josh's lifestyle in the long term. The family had experienced all kinds of issues in trying to support Josh. His sisters and cousin, once they had their own families, found it more difficult to support Josh, whilst being mindful of their own children's safety and well-being. This information was not known to any of the professionals during the scoping period of this review.

5. KEY PHASES

5.1. Throughout this review, housing issues involved two areas of the region. Therefore, for ease of reference, Area A is the area where Josh was deemed to have a local connection and had been living and Area B is the area where Josh wanted to be housed.

5.2. The scoping period was set from March 2018; apart from substance misuse services in Area A, Josh did not come to the attention of other services in the scoping period until July 2018 when he was brought by ambulance to hospital and was reportedly living rough in Area B.

5.3. Information provided by the family indicated that Josh had periodic contact with his sisters and Aunt during this period. Mostly contact was initiated by them to check on how he was. His Aunt made

contact with offers of work. On one of these occasions this caused friction as Josh took money for a job that he did not complete. Some contact with his sisters was asking for money and accommodation. There were periodic messages that indicated that Josh was getting fed up with his life. Josh indicated to professionals that he was estranged from his family.

5.4. Josh's story from first admission to the date of the overdose that resulted in the brain injury happened over 77 days as depicted below:

Day 1-4	Day 6-10	Day 10-Day 36	Day 36-42	Day 43-48
HOSP	HOSP	MHU INPATIENT	HOSP	HOSP

Day 48 -62	DAY 62	DAY 63	DAY 65
HOUSED	HOSP	DISCH	DISCH
		HOSP	
REPEAT ATTENDER PLAN			

DAY 66	DAY 67	DAY 68-DAY 74	DAY 74	DAY 76	DAY 77
HOSP	DISCH	HOSP +HDU	DISCH	DISCH	HOSP
			HOSP		
					BRAIN INJURY

Table One: Map of Admissions

Phase One – July 2018- Day 36

5.5. Josh had been known to substance misuse services in Area A from the date of handover from the previous provider in April 2018. Josh was seen for review on four occasions before his first hospital admission. On three of these occasions he was noted to be injecting heroin, using needle exchanges with use of cocaine on two of those occasions. He was also taking his prescribed methadone[1].

5.6. On day one, Josh called an ambulance as he was unwell. Josh reported that his insulin was out of date, he was sleeping rough and drinking dirty water from an allotment. Josh identified that he was also prescribed methadone for substance misuse. Josh was unkempt in appearance and admitted to hospital for treatment.

5.7. During this admission Josh initially stated a clear intention that he wanted to die. Josh did not like his life and had left his tenancy in Area A as he wanted to get away from drugs and the intimidation of the dealers. Later Josh discussed goals that he wanted to achieve indicating that his intent to die was not as significant as it had been. Josh was seen by the diabetic team and psychiatric liaison service. Josh

[1]**Methadone** is a synthetic opioid drug that can be prescribed to treat chronic pain, but it is most commonly used in the treatment of heroin and opiate drug withdrawal. When administered as part of a medical detox, methadone can help to reduce the severity of symptoms associated with opiate withdrawal. As it produces effects similar to other opioids but without the associated euphoria, it can be effectively used to help in the withdrawal from drugs such as heroin without experiencing the unpleasant symptoms typically associated with detox.

was not given a formal mental health illness diagnosis at that time nor was he open to a mental health team. The plan identified by the psychiatric liaison team was for an urgent referral to adult social care for housing needs and to register with a General Practitioner (GP) to enable his methadone and insulin prescribing in Area B. Josh was also asked to keep in touch with substance misuse services (SMS) in Area A to update them of his address and circumstances. Josh was to be seen again as a follow up for his diabetes and to present himself to the homeless service in Area B on the day of discharge. There is no evidence that a social care referral was sent by the hospital staff on this occasion.

5.8. Josh duly presented himself to the Housing Group Homeless Service in Area B. He relayed his recent history of homelessness and stated that his Employment Support Allowance would start the next day. He stated that he would have access to monies to pay for a self-funding tenancy. The homeless housing coordinator informed Josh that, as his local connection was to Area A (had open tenancy and an open housing benefit claim in Area A) he could not access emergency housing in Area B. Josh was informed of the need to provide ID to the accommodation provider as part of the application process. Josh stated that he had no ID as it had been left in the 'crack house' in area A and that he could not go back there. The homeless advice coordinator reiterated that he would not be able to access self-funded accommodation without ID. Josh got agitated and left.

5.9. Josh returned to the homeless service two days later and asked to see a different advisor. He was accompanied by a friend who is believed to be an ex-girlfriend. The same information was reiterated to Josh. At this point Josh stated that if they were not prepared to help him, he would take an overdose of his insulin there and then. Josh could not be persuaded to refrain from this and duly injected himself and left the building. The homeless advice coordinator called the police and ambulance service. The ambulance service could not be dispatched until Josh was located. Following an intensive investigation and search that involved the housing team viewing the CCTV, police, Mental Health Street Triage team and security guards in the shopping centre, Josh was located an hour and a half later in a local pharmacy. Josh was conveyed to hospital by ambulance. Josh told the ambulance crew of his circumstances and that he could not get help, as the reason for taking the overdose. He stated he was feeling suicidal.

5.10. Josh remained in the acute hospital for four nights. He initially refused to engage with any medical intervention and treatment, he was assessed as having the mental capacity to make decisions regarding his care and treatment. Josh did later engage and accepted treatment.

5.11. Josh was assessed four times on the ward by the psychiatric liaison team. Again, he was found not to have any formal mental health diagnosis but was responding to the stresses of being homeless and that he could not be housed in Area B.

5.12. Josh had been referred to Adult Social Care for a need's assessment by the acute hospital. It was agreed that he should stay on the ward until the social worker visited him on the last day of his admission. It does not appear that this assessment by the social worker took place. The visit by the hospital social worker to the ward would have been due to have taken place within 72 working hours. The referral had been sent on a Friday with ward staff thinking that Josh would receive a visit on the Monday.

5.13. Josh was again assessed by liaison psychiatry on the Monday and was deemed to not have a mental health illness, albeit that significant social stressors were identified. Josh's mental capacity was deemed to be intact although not formally assessed. As Josh continued to say that he did not want to go on living, he was seen as high risk of death, he was offered and accepted an admission to an inpatient mental health bed in order to further assess his mental state and to aid management of current risk.

5.14. During this admission which lasted just under 4 weeks, Josh was subject to ongoing assessment from the mental health team that included risk assessments and support from the mental health unit social worker. It was noted that Josh remained open to substance misuse services in Area A. The review learned that a request to transfer to substance misuse services in Area B had been made and the transfer had commenced. Josh did not attend or engage and therefore the transfer was never completed.

5.15. Discharge planning meetings were taking place that included the Mental Health Trust affective disorders team[2] who would support Josh on discharge. They were also attended by the ward team. The Hospital Inpatient Liaison Team from substance misuse services were invited but did not attend. Contact was made by the mental health team with Area B community substance misuse services the next day. The community substance misuse service planned to see Josh for assessment two weeks later.

5.16. Substance misuse services in Area A had closed their services to Josh as the transfer had been made to Area B. Area B substance misuse services could not prescribe for Josh until they had completed his assessment

5.17. Josh's assessments on the mental health ward indicated a decreased risk and more motivation to change his circumstances with support of the team social worker. His mood was still low; medication was being monitored by the psychiatry team.

5.18. Josh had spent time off the ward during his admission with no apparent concerns.

5.19. Sometime following the discharge meeting Josh attended the ward clinic for his insulin to be drawn up for him to self-administer. Josh quickly altered the dial on the injection pen to give more insulin. The amount given is not known. He stated that he had done it because he had had enough. He refused to have his blood sugar recorded and left the ward. This was a marked change to his behaviour earlier that day.

5.20. A friend of Josh called the Police as he had made contact with her saying that he had taken an overdose. Police located him in the area that the friend had stated, and he walked back to the mental health unit with the police officers after refusing to ride in the police vehicle. Josh remained angry and upset about his impending discharge when he returned to the ward. Josh again left the ward with his friend to go for a walk. She reported that he was argumentative and on a later occasion that he was following her, and she had phoned the police. Josh was eventually returned to the ward accompanied

[2] The affective disorders team provides a range of support and treatment options for adult clients with any form of affective disorders. Affective disorder is a general term used to describe a range of difficulties relating to the way an individual feels, thinks and behaves. The service offers a full range of psychological therapies and medication.

by the Crisis Suite staff as he had presented himself there. Josh refused to engage and went to bed.

5.21. Josh refused to attend the housing provision that had been arranged by the mental health team social worker on the day of discharge. He was later discharged with a plan that consisted of:

- Appointment for assessment with substance misuse services in Area B to start his support and prescription with local services
- Present at homeless service as he had refused the arranged accommodation
- Register with a specified GP practice who would provide his prescription for methadone and other medication
- For follow up with the affective disorders team once he had an address

Key Phase Two- Day 36- Day 62

5.22. When Josh was discharged from the mental health unit, he walked across the hospital site to the acute hospital and presented at the diabetic clinic stating he had taken an overdose of his insulin stating that he wanted to end his life.

5.23. Josh was admitted to hospital and treated for his overdose. He was assessed again by liaison psychiatry the following day as he was medically fit for discharge. Josh then took further overdoses of his insulin. Liaison psychiatry found him to be distressed at his circumstances and fearful of going back to living in the community. Although he was reactive and tearful, he showed no signs of obvious depression or psychosis.

5.24. Josh remained an inpatient. His GP was contacted to see if they would be able to prescribe his insulin daily and observe him administer it in an attempt to prevent further overdoses. The GP practice stated that, whilst they were able to offer daily prescriptions, they could not supervise administration due to resourcing issues. Josh was offered the use of the clinic to receive his daily insulin, but he declined stating that he would continue to take overdoses.

5.25. During this admission, a safeguarding referral was made to the Local Authority. This resulted in initial enquiries by the Adult Safeguarding Team in the Local Authority requesting information from the hospital social worker who went to see Josh. The social worker had made contact with homeless services so was appraised of the circumstances regarding accommodation provision for Josh. When the hospital social worker visited, Josh refused to engage in any assessment and left the ward. Staff on the ward were told by the social worker that if Josh would not engage in an assessment then he could not be helped. No further face to face contact was attempted.

5.26. Josh was also assessed by the substance misuse services Hospital Inpatient Liaison Team, Josh stated that he wanted to re-engage with a methadone programme and consented to community support. Josh was discharged in a taxi to the homeless service in Area B and was also to present himself at the GP practice who had agreed to prescribe his methadone.

5.27. There is no record that Josh attended the homeless service on the day of discharge. Josh failed to attend his appointment with the affective disorders team the next day.

5.28. Later, on the day after discharge, Josh again took an overdose of insulin outside a local pharmacy and was taken to hospital. On this admission he stated that he would continue to take overdoses. The consultant stated that all insulin administration should be supervised. Mental health assessment did not find Josh to be depressed. Josh also took overdoses of insulin whilst he was an inpatient when he was off the ward.

5.29. On discharge the medical consultant stated that he would pay the £50 required to secure accommodation (ID had been gained with the support of the social worker in the mental health team whilst Josh was an inpatient on the mental health ward).

5.30. On this occasion, with the £50 paid by the consultant, Josh was housed as a self-funding tenant in Area B.

5.31. As a response to Josh's continued admissions to hospital from overdoses of insulin, liaison psychiatry arranged a 'Frequent Attender' meeting. This was attended by a social worker, liaison psychiatry, and staff from the acute hospital. The plans agreed by all at the meeting were:

- Staff to remain boundaried, as an intervening approach was thought to be unhelpful to Josh.
- Ward staff to ask for his insulin pen whilst Josh was an in-patient, to stop him taking an overdose whilst an in-patient to extend length of admission.
- Staff to provide a consistent message that Josh needs to engage with substance misuse services.
- The affective disorders team will try and engage Josh in the assessment process, speak to housing providers to identify address and cold call on Josh later that day.
- Any admission of Josh to the acute hospital should be for the shortest possible time.
- The affective disorders team will discuss Josh's children with him and ensure that there are no safeguarding issues.

5.32. The meeting also spent some time considering the issue of staff in the acute hospital ward having to discharge Josh with his insulin, knowing that he would be likely to use this to self-harm. No resolution to this could be found for this situation as Josh's insulin was needed to preserve his life.

5.33. Over the next couple of days, staff from the affective disorders team and the diabetic team visited Josh at his new tenancy. Both reported that he was happy with his accommodation and he was feeling positive. Josh did raise concerns with the diabetic nurse regarding activity taking place within the house as he suspected drug dealing. The diabetes nurse had a conversation with the homeless service to find out information regarding the person living above. The nurse was told that information could not be shared, and intervention was not possible as there was no direct conflict with the two tenants.

5.34. It appears that at some stage Josh left this property and moved to a tenancy that he may have secured by himself as there is no record that this was arranged by professionals.

5.35. Following the initial visits from the teams mentioned above, Josh attended his diabetic clinic appointments but failed to engage in any appointments with the affective disorders team, the GP or the substance misuse services in Area B.

Phase three- Day 62-Day 77

5.36. On day 62 a local pharmacist called for an ambulance. Josh had not eaten for two days, was homeless and had injected insulin with the intent of ending his life. The ambulance service submitted a safeguarding referral due to concerns identified.

5.37. This was followed by continual discharges and admissions throughout this period as depicted in table one at the start of this section.

5.38. Josh stated that he had been again made homeless as he was thrown out by his landlord. On each occasion he was treated by medical staff and reviewed by liaison psychiatry. The repeat attender plan was noted on each admission and was put into action. Josh had various appointments to attend and support networks in place each time he was discharged.

5.39. On one of these admissions, a safeguarding referral was again suggested by a member of the diabetes team. On taking advice from senior nurses, this did not progress as it was advised that Josh did not meet the eligibility criteria for a social worker. The overdoses of insulin were having an increasing impact with seizures noted by attending ambulance crew. The admission on day 68 led to admission to High Dependency Unit (HDU).

5.40. On his penultimate admission further contact was made with adult social care who reiterated that Josh had been seen on a previous admission and that there was no role for social work. Contact was made with housing services who stated that for emergency housing Josh needed to present as homeless to Area A between 08.30 and 17.00. On the day of discharge Josh left the ward from 16.00 until 17.20 and could not be located. When he returned, he was discharged as planned at 17:30.

5.41. The next day at 08.59, Josh was readmitted following seizure activity and reduced conscious level. He had suffered hypoxic/hypoglycaemia encephalopathy (brain injury resulting from low oxygen and low blood glucose levels).

6. THEMATIC ANALYSIS

6.1. This section focuses on areas where learning has occurred. Josh presented the greatest risk to himself by his continual deliberate self-harm by overuse of insulin. It is not his diabetes per se that was an area where learning can occur. His diabetes gave him the ability to have free access to a prescribed medication, that when given in larger than required doses, would cause significant harm. Josh knew this. Josh appeared to be taking large amounts of insulin to gain access to hospital. He stated that he felt hopeless and helpless about his situation and indicated that he felt that no one was helping him.

RESPONSE TO HOMELESSNESS

6.2. On presentation on Day 1, Josh stated that he was homeless. The initial focus was on stabilising his diabetes and to understand his mental health state in order to inform a view regarding the level of mental illness that may have led to his current circumstances. This was good practice. His clinical needs were the main priority on admission. Josh was reported to be low in mood and expressing suicidal thoughts.

6.3. There is a high percentage of homeless people who have mental health issues; therefore, this assessment was essential. Homelessness can occur because people with mental health issues may have difficulties in managing their day to day life, resulting in employment issues and financial management issues. However, the experience of being homeless can be a lonely and traumatic experience[3] thereby may lead to mental ill health and in the extreme, suicide.

6.4. At the time Josh was discharged in a taxi to the homeless service in Area B, there was no referral system in place. When Josh presented to the homeless service, they were reliant on the information given to them by Josh. This information only included his homeless situation and that his ID had been left in a 'crack house' in Area A and that he was unable to retrieve it.

6.5. The homeless advice coordinator was not aware of Josh's history that would indicate his vulnerability or his diabetes. Josh was advised that as his local connection was in Area A, he would need to present there if he wanted emergency funded housing but that he could be housed in Area B if he could self-fund. To do this Josh would need £50 and ID. As Josh could not provide ID, he quickly got agitated and left.

6.6. This became a feature each time he attended housing, with the second occasion resulting in him taking an overdose of insulin whilst at the offices. It is apparent that in all of the conversations that professionals had with each other regarding housing, the technical reasons that Josh could not be housed without money and ID were not fully understood by other professionals. This meant that the circumstances could not be explained fully to Josh by personnel that he had a good relationship with. This was particularly true of the acute hospital staff who were only able to fully understand the housing for the homeless system from this review process.

6.7. Due to the national issues that homelessness presents, The Homelessness Reduction Act (2017)[4] came into force in April 2018. This Act was therefore very new at the time that Josh was presenting as homeless. The 'duty to refer' element that would have meant that the acute hospital would have a duty to refer Josh directly to homeless services, did not become law until October 2018. Had this been in place at the time, homeless services would have had more direct information from acute hospital staff. As a response to this new duty to refer, Area B Housing Group have employed a duty to refer coordinator who is based in the acute hospital emergency department. The role includes training and support for hospital staff regarding the duty and supporting housing issues that are presented by

[3] **Preventing suicide in homeless services** https://www.homeless.org.uk/connect/blogs/2018/jan/04/preventing-suicide-in-homelessness-services Accessed 24 May 2019

[4] http://www.legislation.gov.uk/ukpga/2017/13/pdfs/ukpga_20170013_en.pdf Accessed 24 May 2019

patients in the hospital.

6.8. Some of the features of the new duties on local authorities to prevent and relieve homelessness provide robust assessment and rehousing support. Josh did not engage well with the Homeless Advice Coordinators, therefore the provisions within the Act were limited in their usefulness for Josh. This resulted in no Personalised Housing Plan for Josh. What he appeared to hear was that he needed to go back to Area A or pay and provide ID. Whilst Josh was in receipt of benefits, it was later discovered that he was in debt and therefore his benefits would not be able to provide for his housing needs (i.e. the top up payment in addition to his housing benefit). This therefore had the effect of causing Josh to disengage further.

6.9. There are various ways that housing staff could have been more involved in the discussions regarding the issues that Josh was facing. As it was, there were several telephone conversations from various other professionals to homeless services, but these were stand-alone conversations and not part of any multi agency plan that involved housing staff. This will be picked up on in other sections below.

6.10. Had Josh been engaged further with housing, he could have been made aware that there were ways to access ID and emergency funds that could have helped him. Again, this may have been better explained to him by those that he had good relationships with. Josh had stated to staff when he was in hospital that he consistently felt that people 'fob him off', unbeknown to housing staff, Josh's history of early rejection by his parents possibly meant that this was a further area in his life where he felt rejection.

6.11. It is also of note, that during the mental health unit stay, the mental health team social worker had spent some time with Josh and had managed to secure accommodation for him. This social worker was due to go to the new accommodation with Josh on the pre-arranged discharge date. Due to relationships Josh had formed with other patients whilst he was on the ward, he had been warned that the accommodation that had been suggested was used by drug addicts. Josh therefore refused to go there. It appears that Josh was not just concerned with getting a roof over his head but also staying safe and staying away from drugs.

6.12. Practitioners commented that the reality of the type of accommodation for young single men meant that people with similar issues to Josh were likely to be housed in accommodation deemed suitable. Staff felt that Josh had unrealistic expectations for the housing provision that was available and discussed this with him.

6.13. When Josh did finally accept a tenancy, it was self-funded in Area B. This was made possible by the consultant paying the £50. This may have provided further evidence that it was the finance that was the stumbling block. This was not seen as an issue as his benefits were being paid regularly.

6.14. Whilst Josh was housed, he stayed out of hospital. There were successful visits from professionals, however Josh did raise concerns regarding possible drug activities at the property. This tenancy however soon broke down and it was not long before Josh was presenting back to hospital having taken overdoses of insulin. It is not clear why this tenancy broke down and does not appear to have been questioned when he presented to hospital stating that he was homeless again. It was later that Josh said he owed rent, was in debt and could not go back. It is not clear which property this related to. The

short period of stability was not recognised nor were the reasons for this breakdown questioned.

6.15. The reasons why the response to homelessness of Josh was not successfully addressed were multi-faceted. In this section it has been identified that there was a lack of understanding by professionals as to how the housing system worked, and, as housing staff were not involved in any multi agency meetings, they were not able to have a platform for ensuring that the system could provide what Josh needed and required. Some of the reasons also link to other sections below.

> **Learning Point 1**: Housing staff are better able to meet the needs of homeless people if they are fully appraised of the circumstances related to the person.
> **Learning Point 2**: There is a benefit to homeless people when non housing professionals have a basic understanding of homeless processes.
> **Learning Point 3**: Staff that are known and trusted by a person can act as an advocate to help people navigate difficult to understand systems.

RESPONSE TO REPEAT ATTENDERS and SELF HARM

6.16. Due to the number of admissions that Josh had to the acute hospital, the liaison psychiatry team made the decision that the criteria were met to convene a Frequent Attender Meeting. This meeting is a health led process facilitated by liaison psychiatry. Its purpose is to manage the number of attendances made by those who attend emergency departments on a regular basis with attempts at self-harm and other reasons.

6.17. Addressing frequent attenders is also part of the Acute Hospital Trust process in response to a dedicated CQUIN[5].

6.18. The planning meeting is open to other agencies. In the case of Josh, the staff who attended and the emerging plan are discussed above in para 5.31.

6.19. This process had the potential to be a positive multi agency plan to support and manage the issues that Josh was facing. The meeting focussed on how to deal with Josh on the ward; the psychological understanding of overdose was discussed. The hospital social worker attended and made the decision that there was no role for social work. The Local Authority safeguarding social work team were invited but did not attend as the hospital social work team were attending.

6.20. This meeting happened when Josh had been rehoused at a time when Josh was at his most stable. This was due to the length of time it takes to organise meetings of this nature. Not all of the invited attendees were at the meeting. There are no minutes produced from this meeting, but the care plan was circulated to the acute hospital and substance misuse services.

[5] **CQUIN** stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

6.21. The author notes that there is no multi agency protocol that underpins expectations of this process and there is limited understanding of the process in other agencies. The plans appeared to be task orientated based on risk patterns. It appears that the desired outcomes were related to keeping Josh out of hospital but did not include identifying and addressing the issues that were consistently bringing him into hospital. There were no set review meetings so, in effect, it was a stand-alone plan that was not revisited.

6.22. Hospital staff stated that they felt uncomfortable with the plan and although they referred to it on each subsequent admission, they felt it was not addressing Josh's needs. Staff did not challenge the plan or ask for a review. The plan was not circulated widely enough and police and ambulance services that were responding to crisis points in the community did not know of the plan's existence. Likewise, housing services did not know of the plan. The homeless service team had been identified to be invited by the clinician but were not included when the invitations were sent and therefore were not sent a copy of the plan.

6.23. Whilst a wider circulation of the plan may have helped, the author considers that the plan was too narrowly focussed. Had there been a wider focus and discussion of all of the issues that Josh was facing, it may have been indicated that there was a role for social work and even safeguarding enquiries. Those issues were:

- Inability to maintain a housing tenancy
- Ongoing use of heroin and cocaine and regular use of needle exchanges
- Debt and budgeting issues (now thought to be linked to drug use)
- Ongoing connections in substance misuse circles
- Consistently feeling that his situation was hopeless, and his only way out was death
- The expressed wish to reconnect with family

6.24. It was discussed during the review that the nature of the frequent attender process was necessarily narrow. There was agreement, however, that a joint shared protocol could be inclusive of more agencies in the initial phases to ensure all information pertaining to the person is included. It was also agreed that there could be several different exit points or outcomes from sharing of such information such as a wider multi-disciplinary team meeting or a safeguarding referral.

6.25. There has been work undertaken nationally to manage frequent attenders to emergency departments[6] but also an acknowledgement that frequent attenders, whilst putting a huge burden on resources, have very different reasons for their attendance and therefore 'one size does not fit all' in these cases. Identified as useful in the management of frequent attenders are:

- Emergency departments should have a method of identifying 'Frequent Attenders' to their department.
- Patients who attend the emergency department frequently should be treated with the same care and respect as other patients.

[6] The Royal College of Emergency Medicine Best Practice Guideline: Frequent Attenders in the Emergency Department August 2017

- Patients may benefit from a bespoke emergency department care plan.
- Patients should be given the opportunity to be involved in the production of their care plans and be given a copy of the plan wherever possible.
- Case management for Frequent Attenders may be helpful to identify unmet needs for patients.
- Multidisciplinary case conferences are recommended to improve engagement with community services for some patients. They are also helpful to manage risk for certain patients with risky behaviour.

6.26. It does appear that the current process would benefit from being a multi-agency process that takes into account the above. It would benefit from being person centred and outcome focussed; reducing emergency department attendance may be only one outcome. The process may also lead to other system and agency referrals and reach all agencies that a person has contact with.

Learning Point 4: Multi Agency Processes can be more effective when underpinned by a shared protocol.
Learning Point 5: Management of frequent attenders should consider the reasons for attendance as well as plans for preventing/limiting attendance.
Learning Point 6: Frequent attender meetings may have more successful outcomes if they attract a broader number of agencies, are outcome focussed, have set review dates, produce minutes and plans shared to all relevant agencies (not just attendees).

SUBSTANCE MISUSE & MENTAL CAPACITY

6.27. It has become apparent in gathering information for this review that Josh was using illicit drugs on top of his prescribed methadone more than had been originally thought. The dangers and risks of overdose had been explained to him by substance misuse workers in Area A and Area B. It is identified by examining the dates, that Josh, on at least one occasion, used a needle exchange facility on 2 days at the point of discharge and readmission (Day 35 and 36). Comments from partners indicated that he never appeared under the influence of drugs, this could indicate a significant tolerance level to substances.

6.28. Mental health and acute trust professionals had not recognised the level of substance misuse, although mental health workers did know he was still using illicit substances. There appears to have been some level of communication between Area A substance misuse services and mental health and acute hospital colleagues. This, however, did not lead to the knowledge by acute hospital staff, GP, ambulance or housing of the use of the needle exchange and disclosures of heroin and cocaine use at around the first and second hospital admissions.

6.29. One of the reasons that this information was not known was possibly because substance misuse services in Area B had not been able to assess Josh when he transferred as he had not attended appointments. There had been a full and comprehensive risk assessment in place in Area A, but this was not transferred to Area B on closure of the substance misuse services in Area A.

6.30. Some of the issues in this case were because Josh did not receive an effective assessment from Area B substance misuse services due to his non engagement and that he was often in hospital when appointments had been booked. However, much of the history was lost and did not transfer as the providers in Area A and B were different companies. Josh was seen by hospital substance misuse liaison team when he was an inpatient, but his engagement was sporadic. His assessment though, needed to be carried out by community services in order to reinstate his prescription for methadone in Area B.

6.31. As a result of the issues of making contact with substance misuse service users, substance misuse services in Area B have now introduced a daily drop in service where assessments can be carried out and prescribing done on the same day.

6.32. Due to the way that substance misuse services are commissioned, providers are often different companies. This makes transfer of information complex and necessitates new assessments with the new provider. This not only happens when a person transfers area but also when contracts come to an end and providers change following a tendering process. Professionals both within and outside of substance misuse services report that the constant flux in these services causes confusion and difficulties with the change in providers and assessment processes etc. Current contracts for substance misuse services are often as short as two years, this gives rise to regular changes. It is often the case that the workers do not change as they transfer to the new provider, but the systems are different (assessments and recording systems), and sometimes the type of service provision differs.

6.33. With the amount of information that is not transferred and the confusion for other agencies as well as service users, there is a considerable risk in the system. Substance misuse workers indicate that they do retain the knowledge of their service users even if that historical information has not transferred to new records. It is of note, however, that when a substance misuse worker leaves or changes role, that organisational memory is lost.

6.34. Had the frequent attender meeting been of a broader perspective, and the plan shared with substance misuse services, it may be that the issue of Josh being in hospital could have led to the assessment being carried out on the ward.

6.35. These concerns regarding the commissioning arrangements for substance misuse services have been raised as learning in several Domestic Homicide Reviews and Children's Serious Case reviews in the region; this is therefore a significant issue within the system that commissioners and providers need to address.

6.36. It was felt by most professionals who engaged with Josh, that he had capacity to understand the impact of his actions and that he had the capacity to refuse to engage with services.

6.37. Substance misuse leads to a complex set of circumstances related to mental capacity and also brings into question the appearance of a person making unwise decisions. The provisions of assessing mental capacity and the rights of a person with mental capacity to make unwise decisions is covered by the

Mental Capacity Act (2005). The Mental Capacity Act Code of Practice[7] confirms that people have the right to make decisions that others might think are unwise. It also states, however, there is cause for concern if someone repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or makes a particular unwise decision that is obviously irrational or out of character. The code states that this does not necessarily mean that a person lacks capacity. They may need more information to be able to help them understand the consequences of the decision they are making or there may need to be further investigation as to whether the person has developed a condition that is affecting decision making.

6.38. Josh was considered to have a disorder of the mind or brain due to his substance misuse, his self-harm and suicide presentations. It was possible that due to the influence of drugs, that Josh's mental capacity would be fluctuating. As per the Act, Josh needed to be given opportunities to make some decisions at a time where he was not under the influence of drugs or when he had large amounts of insulin affecting him. This was often the case with staff on the acute hospital wards discussing his care needs with him after the initial crisis was over.

6.39. Staff who did not know about Josh's current substance misuse may have assessed capacity when he was under the influence of drugs. It cannot be determined now, how many decisions Josh made that were non capacitous, if any, due to these issues, but this is using hindsight for learning. Staff who were assessing Josh in an urgent or crisis situation assessed and recorded information regarding his ability to refuse treatment based on the information available to them at the time of the assessment. The findings of their mental capacity assessments were reported to have been comprehensively recorded. When Josh was deemed not to have capacity due his level of consciousness, they intervened and treated him in his best interests. The Mental Capacity Act Code of Practice states that best interests should be based on what decisions a person would make if they had capacity. No clinician, though, without a legally approved advance decision[8] in place, would allow a person to die and not treat them under self-harm and suicidal attempt circumstances, the findings of this review would not disagree with this.

6.40. There are also other considerations that do not directly apply within the Mental Capacity Act, but they do relate to Josh's situation and the decisions he was making regarding his overdoses of insulin.

6.41. Work undertaken by the Samaritans[9] suggests that an understanding of the concepts of agency and control lead to better knowledge of the relationship between socioeconomic disadvantage, self-harm and suicide. Agency is the ability to make choices and take action freely and having control implies a degree of agency. It is suggested that people refer to feeling trapped and having few choices and are linked to the experience of having little control over gaining housing security, getting a job and having positive relationships with others. These, along with the childhood experiences of rejection, could

[7] Department of Constitutional Affairs, (2007) Mental Capacity Act Code of Practice available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf accessed 27 June 2019

[8] Advance decisions are further provisions under the Mental Capacity Act to refuse specified medical treatment at a time in the future, even if this might result in death. Advance decisions should specify which treatment is to be refused and include as much detail as possible regarding the circumstances under which the advance decision will apply. They will only come into force once an individual has lost the capacity.

[9] Samaritans (2017) Dying from inequality Socioeconomic disadvantage and suicidal behaviour

offer an insight into why Josh felt hopeless about his situation. Even when he was housed, there is a possibility (but there is no assured way of knowing), that the same issues that presented in Area A began to be repeated in Area B. He talked of being in debt and this is possibly due to his substance misuse. If he was in debt over rent, it is likely that he was also in debt to drug dealers once again.

6.42. It can be seen why Josh felt that he had no way out and took the decisions that he stated that he would. What is not clear, and it is not possible to know, is why Josh never overdosed on illicit drugs in the period under review given his stated intent to die. Any answers to this would be merely speculation and would not provide any learning for this review.

6.43. Professionals applied the Mental Capacity Act in the best way that they could to support Josh to make wiser choices at a time that he was not under the influence of substances. Issues of 'agency and control' were not understood by staff because they did not have a clear understanding of Josh as the whole person. There had been no fully attended multi agency meeting where knowable information could have been shared and understood by all professionals. This is also discussed in the next section.

Learning Point 7: Understanding lifestyle can support a deeper understanding of decision making and Mental Capacity.
Learning Point 8: People may not have 'agency and control' over their decision making
Learning Point 9: Multi agency working can ensure that all knowable information is shared and may lead to a better understanding of the impact of substance misuse and lifestyle on mental capacity and decision making.
Learning Point 10: Commissioning processes can cause difficulties in effective multi agency working and provision of seamless services

CARE ACT, SAFEGUARDING & SELF NEGLECT

6.44. It is not clear why the hospital social worker did not undertake an assessment of need when a referral was first sent by the hospital on the second admission. It appears that as Josh had gone to the mental health inpatient unit that it was assumed that the assessment was no longer needed.

6.45. Safeguarding considerations were discussed on several occasions. Some professionals were of the belief that as Josh had capacity and was making unwise decisions that there was no role for safeguarding. It was also stated that as Josh had no need of a care package and was homeless that this indicated that he was not eligible for safeguarding.

6.46. One safeguarding referral was not progressed by the Local Authority due to Josh being in hospital with nursing support in place. Another safeguarding referral did lead to a visit on the ward in the acute hospital, but no assessment was completed as Josh failed to engage. The social worker did some information gathering and was aware of many of the issues that Josh was facing.

6.47. A Section 42 enquiry was commenced by the Adult Social Care Safeguarding Team using the information that had been gathered by the hospital social worker from Josh and various professionals. It was deemed that his needs were being met by all of the agencies that were involved and plans that were in place from the frequent attender meeting. Both of the referrals were based on a recognition

of self-neglect by the referrers. The author would suggest that it may have been a better approach for the adult safeguarding social worker to take a more lead role in a Section 42 Enquiry albeit that Josh was in hospital.

6.48. There was much mention of a social worker when Josh was an inpatient on the mental health ward. During the review, it was ascertained that this role was allocated to that unit albeit still employed by the Local Authority. It appears that this was as a result of issues in the transfer of staff from integrated mental health and social work teams to individual services from the Local Authority and health.

6.49. Information gathered in this review indicates that there was a lot of very good work undertaken by this social worker and that there was a good relationship with Josh. The information of any assessment undertaken by this social worker was not known to the Local Authority team as this is not recorded on Local Authority systems. As this social worker is not employed in a role that undertakes statutory duties, assessment of need under the Care Act (Section 9) was not undertaken. There was no recorded communication between this social worker and the other social workers who were involved. The input of that social worker is not included in the report received from the Local Authority for this review but is included in the mental health report.

6.50. The information in the above few paragraphs indicates some concerns for how the safeguarding system regarding self-neglect was understood and applied in this case. The Care Act (2014) is very clear, a person with care and support needs is entitled to be safeguarded whether or not the Local Authority is meeting those needs. Josh therefore did meet the criteria for safeguarding support.

6.51. TSAB's self-neglect policy states clearly in its definition of self-neglect, that it covers a wide range of behaviours including neglecting one's health. Adults can self-neglect through:

> *"Refusal of services that could mitigate the risk to safety and well-being (e.g. lack of engagement with health and/or social care staff and other services/agencies)" p.8*

6.52. The guidance that supports this policy has a specific section on substance misuse and self-neglect. The guidance also reminds staff not to overlook people if they have capacity, are making unwise decisions and withdrawing from services if they to be at significant risk of serious harm.

6.53. It can be seen that these elements of self-neglect fitted Josh completely. Josh was rightly subject to a Section 42 enquiry under a category of self-neglect. This should have been clearly explained to Josh by someone he trusted, and his wishes and feelings ascertained. Josh had consented to the safeguarding referral but did not want intervention from a social worker.

6.54. Although the Care Act places a duty on Local Authorities to undertake safeguarding enquiries, there is also provision to cause others to make enquiries. The refusal of Josh to engage with a social worker did not necessarily mean that he did not want safeguarding support. There were opportunities for health staff to have a greater role in the Section 42 enquiries given that the self-neglect was largely regarding health issues. Information gathered, alongside Josh's wishes should then have resulted in a safeguarding meeting attended by all of those involved. This would have led to a more robust safeguarding enquiry with clear outcomes that were shared to all partners.

6.55. It is important to note that there may have been no role for traditional social work input, given Josh did not want this, but that does not preclude use of Section 42 enquiries as Josh had consented to this. The social work role should have been to cause others to make enquiries using the most appropriate professionals to do this based on existing trusted relationships with the support of internal health safeguarding leads and the Local Authority safeguarding team. The Local Authority safeguarding role would also have been to coordinate the enquiry and chair any multi agency meetings. There is currently no local guidance regarding causing others to make enquiries.

6.56. The opportunity to refer could also have come from the frequent attenders meeting had that have been a more inclusive process. There were social workers who had information that indicated self-neglect that did not invoke or continue with Section 42 enquiries when Josh refused to engage.

6.57. The TSAB Self Neglect Guidance also has provision for a risk and vulnerability panels where, despite best efforts, the risk of harm is escalating or continuing.

> *"The purpose of such panels is to ensure that multi-agency communication and information sharing takes place on a regular basis and to provide support to practitioners and their managers in managing the risks involved in the most complex and challenging cases." P13*

6.58. Some professionals cited not knowing about the guidance and at the time of this review did not know about the risk and vulnerability panels. Of greater concern is that risk and vulnerability panels were not known about by those tasked by the Care Act for the responsibility of undertaking Section 42 enquiries in cases of self-neglect. This appears to be because Area B Local Authority Social Work Teams have not set up the risk and vulnerability panels as required within the guidance. The author was informed that this would be in place soon.

6.59. There was little understanding of this type of situation being self-neglect by some professionals, therefore there was little opportunity for other professionals to challenge that this was not being dealt with under the provisions of the Self Neglect Policy and Guidance. By not drawing together all professionals to safeguard Josh, there were further missed opportunities to share all knowable information. Where referrals were made stating the concern was regarding self-neglect, the response was inadequate with the cited reason that Josh would not engage with the social worker; this did not lead to a full multi agency safeguarding strategy meeting and safeguarding plan.

6.60. The author would suggest that there are a number of adults with care and support needs, who self-neglect, may well have capacity and do not engage with services; the Care Act included those very people to be considered under Section 42 as requiring safeguarding because of the risks of serious harm to this group of people. It also has to be recognised that intervention with Josh may not have been ultimately possible if Josh did not agree, but there should have been a comprehensive gathering of all information to inform a multi-agency risk assessment as required under Section 11 of the Care Act which identifies that a person with capacity is able to refuse an assessment unless they are at risk of harm. In this case there was a risk of harm to Josh and information gathering from all involved agencies could have led to a multi-agency meeting. Risks could also then be escalated within

organisations to more senior managers to supervise and support staff who were involved with Josh.

6.61. When a safeguarding referral was received from the ambulance service, the referral not being progressed due to Josh being in hospital was difficult to understand. There was no liaison with hospital staff to understand what would be in place on discharge so that the concerns and risks would be alleviated. Hospital records did not know about this referral due to an error by the receiving Accident and Emergency nurse on handover from the ambulance staff. Despite that error the referral made to adult social care should have invoked an assessment regardless of hospital admission. It can only be assumed that, as this referral came in after the previous one from the ward, that it was seen that the outcome would not be any different.

6.62. Provisions under the Care Act also identify that a person who is unsupported within safeguarding processes should be entitled to an advocate. It may have been that an advocate would have been able to understand Josh's wishes and feelings and also to help Josh understand the various processes that were impacting on his vision for the future not being met.

6.63. The Care and Support Statutory Guidance Chapter 14 endorses a 'making safeguarding personal' approach[10]. It is of note that the referral from the ward and the ambulance referral had been made with the full knowledge and consent of Josh. Use of a trusted professional from the ward or an advocate may have been a more acceptable approach and may have afforded a better opportunity to gather the wishes and feelings of Josh to inform a care and/or protection plan. It is not known what the impact would have been on Josh of not hearing anything further about the safeguarding referral from the ambulance service.

6.64. No agency or service offered a challenge to the Local Authority who did not undertake assessments or respond to safeguarding referrals in the way that guidance suggests. The Safeguarding Adults Board has a clear procedure of professional challenge published within this review period. It is possible that not all professionals in organisations would know of the guidance, however all safeguarding leads do. It is therefore important that staff alert safeguarding leads when referrals are not responded to in a way that a referrer expects.

Learning Point 11: Self neglect is a complex issue. Practitioners need an in-depth understanding in order to improve safeguarding of people who self-neglect in this way.
Learning Point 12: Procedures and protocols provide frameworks for multi-agency working
Learning Point 13: All agencies must understand safeguarding processes and offer challenge when it appears that referrals are not responded to in the way expected.

[10] **Making Safeguarding Personal (MSP)** is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end. https://www.adass.org.uk/making-safeguarding-personal-publications

Learning Point 14: Where there are multiple roles in a multi-disciplinary team, it is important that when team members are employed by another agency and they have a specific role (i.e. Social worker) that team members are clear on those roles and recording is carried out on the appropriate system so that statutory and other assessment information is available to other social workers in receipt of referrals.
Learning Point 15: Those with statutory responsibilities under the Care Act should be able to evidence an understanding of the various sections of that Act and offer support and guidance to others.
Learning Point 16: It is important to recognise the skills of organisational safeguarding leads and to approach them for advice and support.

COMMUNICATION BETWEEN PROFESSIONALS AND FAMILY

6.65. At the start of this review process, there was a belief by those involved, that Josh had no family who he was in contact with who could support him, stating that he was estranged from his family. It was later ascertained on making contact with family that this was not the case and that, as described earlier in this report, Josh had very supportive family members. It cannot be known now, why Josh chose not to tell professionals of these contacts and it is not for this review to make any assumptions.

6.66. The author has reviewed information from the family and can propose the following analysis and learning.

6.67. Josh identified to various members of staff that he had a desire to reunite and build relationships with his family. Records and information for this review, do not identify evidence that this was explored any further in terms of which family he was talking about. The family knew that Josh desperately wanted to have his mother in his life; this was known to be a very negative relationship. It may have been that Josh was highlighting this as a specific relationship that he wanted to address. Indeed, anecdotal evidence from the family and the professionals in this review, identified that Josh gravitated toward women who were mother figures and being those that he built relationships with and trusted.

6.68. The family members detailed within this report, who the author spoke to, stated that they had reduced contact in order to protect their own and their children's health and well-being, but stated that if they had known the extent to which Josh was harming himself with insulin then they definitely would have preferred to know this. They also indicated that they would have possibly offered him accommodation rather than see him homeless. Much of the details of the period that this review covers were not known to the family at the time.

6.69. This produces a dilemma for professionals who firmly believed that Josh was estranged from his family and that he had no support. As professionals had assessed that Josh had capacity regarding decisions he was making in his life and that he had stated he had no support, they appeared to accept this and there is no evidence that this was explored or challenged during any of the conversations that they had with Josh. Josh had been well known to hospital services for many years and his family details were recorded on systems on previous admissions.

6.70. There is no documented evidence that Josh stated that family could not be contacted, merely that he was estranged from them. This led to a situation where family and professionals were working in parallel lines regarding their current knowledge of Josh. Had there have been a sharing of information and an inclusion of the family, there may have been a better understanding of Josh and other opportunities to meet his needs. This review is not suggesting that data protection or human rights should be breached, just that more in depth conversations regarding making progress on reunification with family which Josh stated was his aim. This may well have been part of care plans from processes mentioned above if they had been more person centred and outcome focussed. In particular, a safeguarding approach that adhered to a 'making safeguarding personal' principle would have very likely included Josh's desire for reunification as part of a person-centred safeguarding plan. The author would suggest that this may have been a protective factor.

Learning Point 17: Person centred and outcome focussed plans ensure that adults' own wishes can be explored in depth towards achieving their desired outcomes.

7. GOOD PRACTICE

7.1. It is important to note that many practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. This review has identified some good use of processes and a passion to try and support Josh. Whilst recognising areas for improved practice and learning, Safeguarding Adult Reviews can also provide evidence of good practice. Attendees at the workshop were asked to identify these from their own and other agencies involvement. It is important to highlight these as areas where learning can occur.

7.2. The following was identified as good practice:

- Josh was provided with an alternative homeless advice coordinator when he refused to see an advisor he had previously seen.
- Efforts made by all services to locate Josh when he took an overdose of insulin in the housing offices.
- Solution found by housing officer to ensure a doctor could pay the required fee on behalf of Josh.
- All key agencies kept the GP up to date by sending admission and discharge letters.
- There was good communication between the substance misuse inpatient liaison service in Area B and the locality substance misuse service teams. These teams also provided Josh with harm minimisation information when he was seen face to face on the ward or at the needle exchange.
- Substance misuse services in area A had a detailed and comprehensive risk assessment that was specific to Josh.
- Area A substance misuse services offered regular appointments with both non-medical prescriber and recovery navigators, as well as good communication with the hospital, pharmacies and specialist GP practice.

- Ambulance service triage recognised concerns and raised them to ensure a more immediate response and triaged time was overridden. There were further similarities in upgrading response times in relation to perceived need.
- The paramedic safeguarding referral was of high quality and contained consent from Josh.
- The psychiatric liaison team worked well with the Acute Hospital.
- The frequent attender meeting was attended by several agencies.
- There was some good recording of discharge arrangements by staff in the acute hospital
- Capacity assessments detailed specific risks to Josh.
- The diabetes team offered a flexible service in an attempt to keep Josh engaged.
- Josh was often allowed to stay extra nights in hospital with evidence of very good caring and provision of clothes and other essentials by the nursing staff.
- Police engaged with Josh to ensure he returned back to the mental health unit under his terms.
- There was good communication between liaison psychiatry and the acute hospital wards.
- A lot of staff went over and above what would be expected of them to keep Josh safe.

8. CONCLUSION: MULTI AGENCY WORKING & COMMUNICATION

8.1. Notwithstanding the above good practice, it can be identified in drawing together conclusions in this case, that learning relates to the use of systems to support multi agency working. These may have provided a more cohesive approach to safeguarding Josh that incorporated his wishes and feelings.

8.2. In thinking about the housing issues presented in this case, there would have been a benefit from robust communication between all of the professionals involved, including housing staff. This would have helped an understanding of housing processes and legislation by other professionals and would have helped housing staff to have understood more fully, the circumstances facing Josh. It is acknowledged that since the 'duty to refer' has been invoked, that there is better communication between the acute hospital and housing. The result of this review has also led to professionals indicating that they will invite housing staff to meetings in the future, where relevant.

8.3. A multi-agency frequent attenders protocol that led to a multi-disciplinary meeting attended by all relevant professionals may have had a twofold outcome, one that focussed on keeping Josh in hospital for the least amount of time, and also one that focussed on action and prevention of the issues that Josh was facing that led him to feel a need to be in hospital. A recommendation of this review relates to possible exit pathways from an initial frequent attender meeting dependant on the circumstances.

8.4. A more holistic approach to Josh may have led to a deeper understanding of his level of substance misuse and how that may have been impacting on his decisional capacity and his ability to use and weigh information that had been relayed to him. It may also have led to a deeper understanding of Josh, the person, and that his 'agency and control' were affected by his personal circumstances that were leading to the helpless situation that he declared he was in, leading to him seeing the only way out was to end his life.

8.5. A deeper understanding of the Care Act, and in particular safeguarding and self-neglect may have led to a forum for agencies to come together with the added element of organisational safeguarding leads who may have given an expert and objective view. The progression of the Section 42 enquiry using the self-neglect policy leading to a risk and vulnerability panel would have brought a wider group of professionals together for a more robust multi agency response. A making safeguarding personal approach could have led to exploration of family support.

8.6. It is of concern that the staff within the agency tasked with responsibilities under the Care Act appeared not to utilise the safeguarding duties and self-neglect policy and guidance fully in the way it was intended and identifies concerns in the safeguarding system.

8.7. None of the systems and responses involved with Josh provided clarity on any key worker role. When there are several agencies involved, multi-agency communication is aided by a key worker role to coordinate all multi agency communication. This is not only helpful to the person but also the other professionals involved. Josh was not subject to any system that required a key worker. The author would suggest that with robust use of the frequent attender process and/or Care Act processes, then a key worker role could have been identified.

8.8. Many professionals invested their time to care for and support Josh. It is not clear that if the above systems had been applied and understood and challenged more robustly, that the outcome for Josh would have been any different. A review of the circumstances, however, would have led to a view that every avenue had been tried. This was not the case and therefore leads to the recommendations highlighted in the following section.

9. RECOMMENDATIONS

9.1. The findings identified above have been included in learning points throughout this report and lead to recommendations for improvement.

9.2. Where agencies have made their own recommendations in their Agency Review Reports, TSAB should seek assurance that action plans are underway, and outcomes are impact assessed within those organisations.

9.3. The following multi agency recommendations are made to the TSAB as a result of the learning in this case:

1. The Safeguarding System

a. TSAB must seek assurance, through a peer review, that the relevant Local Authority Adult Social Care Service with statutory duties under the Care Act, are carrying out those duties effectively in order to safeguard the people in need of care and support in the locality where this case occurred. **(Learning Point 15)**

b. TSAB should undertake an appreciative enquiry approach and seek cases to be presented to Board meetings where a person has been successfully protected from harm following a safeguarding referral. **(Learning Point 15)**

c. TSAB should consider providing supplementary guidance for occasions when it is more appropriate to cause others to make enquiries. **(Learning Point 15)**

d. TSAB should produce a learning briefing to remind all professionals of the effective use of the safeguarding system to protect vulnerable individuals in need of care and support. The use of the Professional Challenge Procedure should be included. Agencies should include professional challenge in their single and multi-agency safeguarding training at all appropriate levels. **(Learning Point 13)**

2. TSAB must seek assurance from local authorities and health trusts that there is clarity on any social work roles outside of the Local Authority teams. This must include declaration of those with social work roles, whether they are statutory or non-statutory roles, as well as supervision and management responsibility for those roles. **(Learning Point 14)**

3. TSAB should produce a learning briefing regarding information about homelessness and the new legislation as well as duty to refer for all agencies. The briefing should cover support and advocacy that can be offered. **(Learning Points 1, 2 &3)**

4. **Self-Neglect**

a. TSAB must refresh and relaunch the Self Neglect Guidance, supported by an awareness raising campaign with a focus on 'non-typical' self-neglect.

b. Agencies that have their own Self Neglect Policies should ensure it is congruent with the TSAB Policy and guidance or adopt the TSAB Policy and Guidance.

c. TSAB, through its quality assurance role, should carry out multi-agency audits on self-neglect cases to assess the success of the relaunch and learning from this SAR. Audit should include a baseline audit followed by a further progress audit. Audits should cover evidence of professional challenge and managerial oversight of complex cases.
(Learning Points 7-12)

5. TSAB should ask the relevant agencies to build on the current process and develop a shared protocol for repeat attenders to the emergency department that is based on best practice and current evidence of what works. The protocol should include

- Being inclusive of more agencies (including emergency services) in the initial phases to ensure all information pertaining to the person is included
- Being outcome focussed
- Being person-centred
- Identification of different exit points or outcomes from sharing information such as a wider multi-disciplinary team meeting or a safeguarding referral etc.
- Clear ownership
- Review dates and progress against plan.
(Learning Points 4, 5, 6, 9, 12 & 17)

6. In light of the learning from this and other local reviews, TSAB should seek assurance and an update from commissioners of substance misuse services regarding progress to ensure that the contracting and retendering process includes smooth transitions from one provider to another. Assurance is needed that information is not lost, and that assessments and risks are transferred without the need to immediately reassess. Length of contracts also needs consideration in order to reduce ongoing flux

in the system (**Learning Point 10)**

7. TSAB must produce a briefing related to all learning points from this SAR.

Appendix One Terms of Reference (REDACTED)

Safeguarding Adults Review
Case 5/18
Josh
Terms of Reference and Scope

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and TSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

Josh was a young man in his late twenties who was homeless and had diabetes. He had taken multiple overdoses of his insulin which has resulted in a number of admissions to hospital due to self-neglect of his diabetes and misuse of medication. The taking of too much insulin (or not enough) leads to life threatening emergencies. As a result of a significant overdose of insulin, Josh suffered a permanent and life changing brain injury and it was believed that he was likely to have additional care and support needs for the rest of his life. Josh, however passed away unexpectedly in hospital on 2nd January 2019.

3. Decision to hold a Learning Lessons Review

The Safeguarding Adults Review Sub Group of the Safeguarding Adults Board met on 12th November 2018 and following the gathering of more information and the death of Josh, a further meeting on 23rd January 2019 agreed that the criteria for a Safeguarding Adults Review were met and made a recommendation to the TSAB Independent Chair. The Independent Chair endorsed this decision. It is

of note that it was the issue of self-neglect of his diabetes where the criteria are met for a SAR and not the death in hospital for which the cause is not currently known.

4. Scope

The review will cover the period **01/03/18 and 21/09/18.** This is the period that covers identification of considerable numbers of contacts with agencies. Key background information will also form part of the review that will inform the more contemporary elements of Josh's journey.

5. Method

In determining the methodology to be used for this Learning Lessons Review the TSAB considered the Care Act 2014 Statutory Guidance which states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

TSAB chose to use a methodology that engages frontline practitioners and their line managers. Agencies are asked to review their own involvement and provide a report of their findings and learning. Those who were involved, alongside the authors of the reviews will then be invited to engage in a Learning and Reflection Workshop to review all of the material and identify key themes and learning. A Review workshop will take place to review the first draft of the overview report.

6. Key Lines of Enquiry to be addressed

As well as broader analysis provided within the Agency Review Reports the following case specific key lines of enquiry will be addressed.

6.1. Assessment

What assessment did your agency undertake of Josh's holistic needs, inclusive of physical and mental health? How robust was this? How did this inform care planning and interventions? Please provide analysis of what assessment policies and frameworks were in use and identify any gaps in policy and/or practice.

6.2. Multi Agency Working

What did your agency understand of the other agencies involved? What evidence is there regarding multi agency coordination and sharing of risks, assessments and plans? Discuss this in terms of what would be expected for multi-agency working in a case of this nature.

6.3. Responding to Crisis

How did your agency engage in responding to crisis points that Josh experienced? Were there any specific multi agency plans and responses to manage risk of suicide or death by misadventure?

Analyse effectiveness of responses and suggest learning from this.

6.4. Safeguarding and Risk Management

How were risk management and safeguarding processes applied? Provide evidence and discuss this against expected risk management processes.

6.5. Referrals

Were appropriate referrals made to, and information shared with, other agencies and services when required? Where referrals were made, please analyse timeliness and quality of referrals and responses received. If necessary, where referrals were not made, please provide a reason. Please identify and analyse any actions taken if referrals did not receive the expected response.

6.6. Mental Health Act, Mental Capacity Act and Human Rights

Analyse how the balance between use of these Acts were demonstrated within your agency. How did this support risk management? Was there any evidence of professional challenge? How effective were these Acts in keeping Josh safe?

6.7. Cross Border working

Please identify any issues raised by Local Authority or organisational borders. How well was information shared across border systems e.g. Health, Adult Social Care, etc.

6.8. Family Involvement

How did your agency engage with Josh's family and girlfriend? What did you understand of the relationship between Josh and family? How were they included in plans and assessments? Were there any issues of consent and confidentiality?

6.9. Documentation

Please identify if documentation was in line with agency requirements. If not, please analyse why this might be.

6.10. Good Practice

Please identify examples of good practice from your agency and others.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Lessons Learned Review is **Karen Rees.**

8. Organisations to be involved with the review:

- Hospitals NHS Foundation Trust,
- GP
- Housing Group 1
- Housing Group 2
- Mental Health NHS Foundation Trust
- Area B Borough Council Adult Social Care
- Area A Borough Council Adult Social Care
- Ambulance Service
- Police
- Substance Misuse Services
- Council Housing Department Area A

Historical summary reports will be requested from:

- Area B Children's Social Care
- Area A Children's Social Care

9. Family Involvement

A key part of undertaking a SAR is to gather the views of the family and share findings with them prior to finalisation of the report. Josh was estranged from his family. At the time of the writing of these terms of reference, TSAB were making attempts to make contact with family members. The Independent Reviewer will make arrangements to meet with the family.

10. Project Plan dates:

	Date
Scoping Meeting (Governance Group)	19/03/2019
Terms of Reference updated	As above
Agency Authors' Briefing	As above
Agency Review Reports submitted	30/04/2019
Review of Reports by Independent Author	1-3/05/2019
Distribution of Reports to all Learning & Reflection Workshop attendees	08/05/2019
Learning and Reflection Workshop (Full Day)	16/05/2019
First Draft Overview Report to all attendees	21/06/2019
Learning and Reflection Review Workshop	03/07/2019
V2 Overview report circulated to workshop attendees	17/07/2019
Comments on V2	24/07/2019
V3 to SAR/Governance Sub Group	23/08/2019
SAR / Governance Sub-Group to agree workable achievable recommendations and agree report prior to presentation at Board.	25/09/2019
Presentation to TSAB Meeting	28/11/2019

Appendix Two

Type 1 Diabetes Mellitus (Extract from Acute Hospital Trust Report)

Diabetes Mellitus is a syndrome characterised by raised blood glucose level associated with a deficiency or lack of effectiveness of insulin (a hormone secreted by the pancreas). Insulin secretion is dependent on the level of glucose in the blood. Following the ingestion of food, glucose levels rise, and insulin is secreted facilitating the glucose to enter the cells to be utilised for energy. Excess glucose is stored in the liver, muscles and as body fat. With insufficient insulin, a body cannot utilise its glucose which accumulates in the blood, spilling over into urine. In Type 1 diabetes mellitus a person is dependent on insulin medication and without it would eventually die, conversely in Type 2 diabetes mellitus a person may or may not be receiving some insulin, but could live without it.

Insulin as a medication is a solution which is injected just beneath the skin; it may be long acting delivering a steady background level over a 24 hour period; short acting over several hours to cover food ingestion or a mixture of both. Storage of insulin that is not in use should be in the refrigerator; in the absence of a refrigerator it can be kept at room temperature (15-25 degrees Celsius) for 28 days to remain effective. In use insulin cartridges should not be refrigerated and may be kept at room temperature for 28 days.

Long term complications of diabetes can be divided into small vessel disease (affecting eyes, kidneys and sensory loss to peripheral nerves) and large vessel disease (affecting circulation to heart, brain and feet). Damage to the skin of the feet in the presence of both small and large vessel disease is one reason for amputations in people with diabetes.

There are two diabetic emergencies; 1. Hypoglycaemia which occurs when blood glucose fall low; this could be caused by the administration of too much insulin, missed or delayed meals, alcohol or excessive exercise. Treatment for hypoglycaemia is either oral glucose or intravenous (IV) dextrose. Glucagon may be given intramuscularly (IM) in the absence of IV dextrose; this a hormone produced by the pancreas that causes stored glucose to be released; 2. Diabetic ketoacidosis (DKA) which occurs when there is insufficient insulin in the body and fat stores have to be utilised for energy which produces a chemical called ketones. DKA can be caused by illness increasing a person's insulin requirement, vomiting, uncontrolled or undiagnosed diabetes. Treatment for DKA is IV infusion of fluids and insulin in response to the regularly monitored level of glucose. Without treatment for DKA a person will become drowsy and then fall into a coma and potentially die.